

Medicaid and the District of Columbia

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Projected gross Medicaid expenditures for FY 2005 totals \$1.3 billion, making Medicaid the largest program operated by the District Government. In terms of local funding, Medicaid ranks second only behind D.C. Public Schools, highlighting the magnitude and importance of the program.

The District Department of Health/Medical Assistance Administration (MAA) is the single state agency responsible for Medicaid.* The MAA oversees all Medicaid programs, which include managed care providers, fee-for-service (FFS) providers, institutional providers, and District agencies that provide services to Medicaid-eligible residents, known as the "public providers." The MAA has delegated operational responsibility for some portions of the District's Medicaid program in the following manner:

1. District of Columbia Public Schools - School-Based Clinics
2. Department of Mental Health - Community-Based Rehabilitation Option/Mental Health Hospitalization
3. Child and Family Services Agency - Targeted Case Management/Rehabilitation Option
4. Department of Human Services/Mental Retardation and Developmental Disabilities Administration - Mental Retardation and Developmental Disabilities Waiver.

Background

Created as Title XIX of the Social Security Act in 1965, Medicaid is a federal/state program administered by the states and funded by state and federal revenue. For 30 years Medicaid has operated as an entitlement program for individuals. That is, anyone who meets specified eligibility criteria is "entitled" to Medicaid services offered by certified providers. Federal law establishes minimum eligibility and service levels and standards, state funding participation requirements, and quality and scope of medical services. Beyond these minimum requirements, states have flexibility to determine additional eligibility categories, reimbursement rates, benefits and service delivery.

Medicaid operates as a vendor payment program. States are allowed to reimburse health care providers directly on a fee-for-service (FFS) basis, or via prepayment arrangements, such as managed care organizations (MCOs). The District, like most jurisdictions, does both. Within federally imposed upper and in some cases, lower limits and specific restrictions, each state has broad discretion in determining the payment methodology and payment rate for services. Providers of services participating in Medicaid must accept Medicaid payment rates as payment in full, regardless of actual costs. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid beneficiaries and/or to other low-income or uninsured persons under what is known as the disproportionate share hospital (DSH) adjustment.

States may impose cost sharing arrangements on some Medicaid beneficiaries for certain services through deductibles, coinsurance, or co-payments. However, pregnant women, children under age 18, and hospital or nursing home patients who are expected to contribute most of their income to institutional care are

* As required by Title XIX of the Social Security Act, each state must designate an agency to administer the program. This is accomplished within DC Code 1-307.02 - 1-307.06

excluded from these arrangements. In addition, states may not impose co-payments for emergency services and family planning services.

The federal government pays a share of the medical assistance expenditures under each state's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP), is determined annually by a formula that compares the state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent or higher than 83 percent. The District of Columbia is exempt from this formula as its FMAP was permanently raised from 50 percent to 70 percent in the Balanced Budget Act 1997 (Public Law 105-33).

D.C.'s Benefit Package

Federal law allows considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory in order to receive federal matching funds. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations. These services include:

- Inpatient and outpatient hospital services
- Prenatal care
- Vaccines for children
- Physician services
- Nursing facility services for persons aged 21 or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for persons eligible for skilled-nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse-midwife services
- Federally qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings
- Early and periodic screening, diagnostic, and treatment (EPSDT) for children

States may also receive federal matching funds to provide certain optional services. The District offers the following optional services:

- Inpatient Psychiatric
- Dental
- Prescribed Drugs
- Durable Medical Equipment
- Medical Supplies
- Optometry/Eye Glasses
- Residential Treatment Facilities
- Intermediate Care Facilities/Mental Retardation and Day Treatment
- Personal Care
- Home and Community Based Services
- Home Health
- Case Management
- Hospice

The District's Waiver Programs

Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects that are likely to promote the objectives of the program. Implemented as "demonstration waivers," the "1115 waiver" process allows states to provide services that are not otherwise matchable and/or allows expansion of eligibility for those who would otherwise not be eligible. Demonstration waivers must be budget neutral over the life of the project (generally 5 years) in terms of providing services to the waiver-eligible population and cannot be expected to cost the federal government more than it would cost to provide services to this population without the waiver.

Approved waivers in the District include:

1. *Home and Community Based Services for the Elderly and Persons with Disabilities*
 - This waiver provides home and community based services to the elderly and individuals with physical disabilities ages 19-64, in addition to attendant care and assisted living services.
 - This waiver is currently serving 334 consumers and is programmed to serve a maximum of 980.
2. *Mental Retardation/Developmental Disabilities*
 - This waiver provides a wide range of services and in settings that were not traditionally covered by the Medicaid program. This program is for individuals certified to require a level of care from an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or persons with related conditions. Many of these individuals would have to be cared for by the Mental Retardation and Developmental Disabilities Administration with local funds if this waiver were not in effect.
 - This waiver is currently serving 432 consumers and is programmed to serve a maximum of 725.
3. *HIV/AIDS Water Filter*
 - This waiver provides services related to the use of a water purifier and replacement filter system.
 - This waiver is currently serving 126 consumers and is programmed to serve a maximum of 1,632.
4. *HIV Demonstration Expansion*
 - This waiver provides coverage to individuals with HIV with incomes less than 100 percent of the federal poverty level who do not meet disability criteria. This is an approved waiver that is expected to have its first clients enrolled in June 2004.
 - This waiver is not currently serving consumers and is programmed to serve a maximum of 125.
5. *Childless Adults Ages 50 - 64 Up to 50 percent of the Federal Poverty Level*
 - This waiver expands coverage to childless adults between the ages of 50-64 up to 50 percent of the federal poverty level. It is funded with DSH money that would otherwise go to many of the District's hospitals.
 - This waiver is currently serving 1,484 consumers and is programmed to serve a maximum of 2,400.

6. *1915(b) Freedom of Choice Waiver*

- This waiver provides comprehensive medical services to Temporary Assistance to Needy Families (TANF) and TANF-related Medicaid recipients, under the District's Medicaid managed care program. This waiver allows the District to utilize managed care rather than the fee-for-service program for this mandatory population.
- This waiver serves 91,000 consumers and does not have a programmed maximum.

Important Trends and Benchmarks

Because of the District's proximity to Maryland and Virginia, benefit parity is a key management consideration. Parity can be viewed through three perspectives: services offered, eligibility, and other program characteristics.

Services Offered

Table 2-1 compares the District's Medicaid benefit package to those of Maryland and Virginia.

Table 2-1

Comparison of Medicaid Programs

Type of Benefit	District of Columbia	Maryland	Virginia
Ambulatory Surgery Center	✓		✓
Clinic Services - Public and Mental Health Clinics		✓	✓
Federally Qualified Health Center Services	✓	✓	✓
Outpatient Hospital Services	✓	✓	✓
Religious Non-Medical Health Care Institution & Practitioner Services			✓
Rural Health Clinic Services			✓
Dental Services	✓*	✓	✓
Eyeglasses	✓		
Speech, Hearing & Language Services	✓*	✓	
Laboratory and X-Ray Services	✓	✓	✓
Medical Equipment and Supplies	✓	✓	✓
Prosthetic and Orthotic Devices	✓		✓
Inpatient Hospital Services	✓	✓	✓
Diagnostic, Screening and Preventive Services	✓		✓
Rehabilitation Services: Mental Health and Substance Abuse	✓*	✓	✓
Certified Registered Nurse Anesthetist Services		✓	
Medical Surgical Services of a Dentist	✓	✓	✓
Nurse Midwife Services	✓	✓	✓
Nurse Practitioner Services	✓	✓	✓
Optometrist Services	✓	✓	✓
Physician Services	✓	✓	✓
Podiatrist Services	✓	✓	✓
Prescription Drugs	✓	✓	✓
Physical Therapy Services	✓	✓	
Occupational Therapy Services	✓		
Ambulance Services	✓	✓	✓
Non-Emergency Medical Transportation Services	✓*	✓	✓

Home Health Services	✓	✓	✓
Hospice Services	✓	✓	✓
Personal Care Services	✓	✓	
Private Duty Nursing Services	✓		
Targeted Case Management	✓	✓	✓
Inpatient Psychiatric Services, Under Age 21	✓	✓	
Inpatient Hospital Nursing Facility and Intermediate Care Facility Services in Institutions for Mental Disease, Age 65 and Older	✓	✓	
Institutions for Mental Disease	✓	✓	✓
Intermediate Care Facility Services for the Mentally Retarded	✓	✓	✓
Nursing Facility Services	✓	✓	✓

Data Source: Kaiser Commission on Medicaid and the Uninsured, March 2003

Note: Services marked with * are provided to limited populations.

Eligibility

While the District's benefit package does not differ significantly from the Maryland and Virginia Medicaid programs, what is not borne out by the comparison is the differences in population coverage with respect to the federal poverty level.

Table 2-2 - Shows the comparative coverage levels as a percentage of the federal poverty level.

Table 2-2

Coverage Comparison as a Percentage of the Federal Poverty Level

	Federal	District of Columbia	Maryland	Virginia
Children 0 - 1	133	200	300	200
Children 1 - 5	133	200	300	200
Children 6 - 19	100	200	300	200
Pregnant Women	133	200	185	133
Immigrant Children	0	200	0	0
Blind, Elderly & Disabled	100	100	100	100

Data Source: Medical Assistance Administration

Note: The District also covers families of Medicaid children. These individuals are not covered in Virginia or Maryland. In those states, the coverage above 200 percent is partial.

Other Program Characteristics

In addition to differences in coverage levels, the District's expenditure patterns differ significantly from Maryland and Virginia. According to the Federal Center for Medicare and Medicaid Services' Medicaid Management Information System:

- Medicaid covers 25 percent of the District's population, compared with 9 percent in Virginia and 12 percent in Maryland and 11.6 percent nationally.
- D.C. spends on average \$7,242 per Medicaid enrollee compared with \$5,177 in Virginia and \$5,509 in Maryland.
- The District spends \$1,776 per resident on Medicaid compared with \$45 in Virginia and \$649 in Maryland.

The amounts for the District are likely higher because the District covers more adults than the other pro-

grams and the cost of caring for them is more expensive. The District is also a relatively high cost area, meaning that the price of providing health care services is much higher than in Maryland and Virginia. Whereas Maryland and Virginia have rural and suburban areas to help offset the higher cost of medical care in urban areas, the District does not.

Medicaid Revenues

All Medicaid expenditures are initially paid for with local funds and then federal reimbursement is sought for the FMAP portion of the expenditures. The Department of Health has a dedicated Medicaid program that tracks both local expenditures and federal revenues. However, the case is different for the public providers. Because the public providers manage programs that serve populations defined by program eligibility rather than Medicaid eligibility, there is not a separate accounting for the local expenditures in the District's financial system. Thus, Medicaid expenditures show up across several programs within each of the agencies. Once federal reimbursement is received, the funds are recognized as federal revenue and a journal entry is made to move the FMAP portion to a distinct federal Medicaid fund. This arrangement makes it difficult to quantify with any certainty the local funds associated with the Medicaid program. It also means a program analysis of the public provider Medicaid revenues cannot be performed because they are accounted for together in the journal entry process. Beginning in FY 2004, the Department of Health and the public provider agencies set up Intra-District funds to recognize Medicaid revenues by program.

The following table shows the breakdown of the District's Medicaid revenues for the Department of Health and the public providers for FYs 2001 through 2003 as accounted in SOAR.

Table 2-3 - Shows the breakdown of the District's Medicaid revenue for the Department of Health and the public providers for FYs 2001 through 2003 as accounted for in the District's financial system.

Table 2-3

Medicaid Expenditures in the District, FY 2001-FY 2003*

	2001	2002	2003
Agency			
Department of Human Services	\$9,528,311	\$12,061,108	\$10,572,338
Department of Mental Health	\$41,002,720	\$26,636,519	\$35,405,101
D.C. Public Schools	\$19,658,642	\$23,014,298	\$23,073,143
Child and Family Services Agency	\$41,083,195	\$23,595,312	\$32,617,737
Department of Health/MAA	\$657,264,848	\$740,400,93	\$703,679,057
TOTALS	\$1,009,548,621	\$989,091,634	\$1,109,955,508

*Federal funds only. Data gathered from District's financial system.

Medicaid Accounts Receivable Writeoffs

Because the District does not always receive reimbursements by the close of the fiscal year for claims filed in that year, agencies estimate amounts that are forthcoming and account for them that year as receivables from the federal government. Recent experience in the program has shown that a portion of these receivables will not actually result in federal reimbursement. Reasons for not receiving reimbursement include claims that have been filed incorrectly or too late, or claims judged to be for a service or a recipient who is not Medicaid-eligible. When this happens, the agency must write off the receivable, that is, recognize

the loss of the anticipated revenue in the year that the decision is made. Another potential loss results from a "disallowance" of certain costs incurred and reimbursed in a previous year. When this happens, the agency must repay the reimbursement received in a previous year--that is, recognize the loss of the previously reported revenue--in the year the repayment is requested by the federal government. These transactions appear as an increased local funds expenditure in the year of the write-off, or disallowance payment, because the expenditures that were originally charged against the federal receivable/revenue must now be charged to the local budget.

Table 2-4 - Shows the effects of Medicaid writeoff on local funds expenditures on the public provider agency local funds expenditures.

Table 2-4

Effect of Medicaid Writeoffs on Local Funds Expenditures, Public Provider Agencies

	2001	2002	2003
Agency			
Department of Mental Health:			
Base Expenditures	41,003	26,637	35,405
Medicaid Receivable Write-offs	107,107	0	52,137
Medicaid Grant Disallowances*	39,606	0	8,607
Total Agency Expenditures	187,716	26,637	96,149
D.C. Public Schools:			
Base Expenditures	19,659	23,014	23,073
Medicaid Receivable Write-offs	0	0	0
Medicaid Grant Disallowances*	17,334	5,000	
Total Agency Expenditures	36,993	28,014	23,073
Child and Family Services:			
Base Expenditures	36,861	11,930	32,618
Medicaid Receivable Write-offs	0	16,547	0
Medicaid Grant Disallowances*	0	0	0
Total Agency Expenditures	36,861	28,477	32,618
Total Expenditures - All Agencies	\$261,570	\$83,128	\$151,840

* The total of Medicaid grant disallowances are anticipated to be repaid from the Fund Balance before the end of FY 2004.

¹ The base expenditures for FY2001 and FY2002 are from the SOAR DAFR520 report. The base expenditures for FY 2003 are from the SOAR Inquiry Screen 89, Appropriated Fund 0250.

Medicaid Reserve

As part of the District-wide Medicaid reform effort, the Medicaid Reserve was established in FY 2003 to account for possible revenue shortfalls within agencies that are public providers of Medicaid, Medicare and other federal reimbursable services. The requirements for allocating the reserve include the public provider agencies submitting either a plan to generate savings comparable to the funds allocated from the reserve or a performance plan to ensure future reductions of costs and maximization of third-party revenues. The Office of the Chief Financial Officer was required to certify the agencies' plans that were submitted by the Office of Medicaid Operations Reform.

Table 2-5 - Shows the FY 2003 actual reserve allocations and the FY 2004 proposed allocations by agency.

Table 2-5

Medicaid Reserve Allocations

Agency	FY 2003 Reserve Allocation	FY 2004 Proposed Allocation
Department of Human Services	\$7,795,000	\$7,795,000
Child & Family Services Agency	\$17,220,000	\$18,743,901
Department of Mental Health	\$35,352,000	\$21,728,099
D.C. Public Schools	\$13,771,000	\$6,815,699
TOTAL	\$74,138,000	\$55,082,699

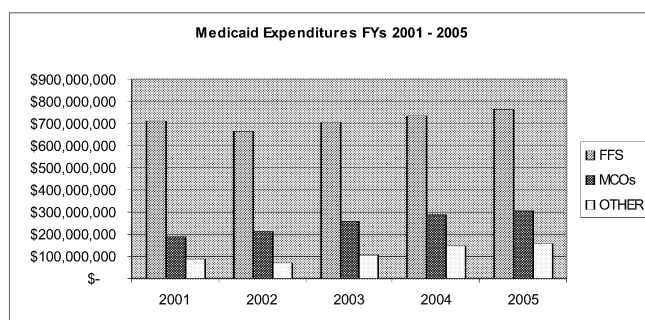
For FY 2005, no funding is proposed for the Medicaid Reserve. Based on the two-year history of public provider collections and other analyses, the baseline funding levels for the public provider agencies have been adjusted to reflect planned agency activities and realistic federal reimbursement revenue.

Why Costs Are Rising

The FY 2005 proposed gross Medicaid budget for all District agencies is approximately \$1.411 billion. Of that:

- \$103,326,227 in Federal Medicaid funds is designated for public providers, which represents eight percent of the gross budget;
- \$308,429,188 is designated for managed care, representing 21.8 percent of the gross budget;
- \$790,169,073 is designated for services not accounted for in managed care, representing 56% of the gross District budget.

Figure 1: Medicaid Growth, FY 2000 - FY 2004



National research points to continuing Medicaid cost increases at rates higher than revenue growth among the states. There are several primary contributing factors, including an expanding aging population and their associated need for hospital stays and nursing homes, the increases in prescription drug costs and general enrollment growth. For the District, in FY 2005, these factors are highlighted as follows:

- The gross budget for Disability and Aging Programs is \$594,484,043, which represents 42.1 percent of the gross District Medicaid budget; and
- The gross budget for Children and Families Programs is \$76,591,742, which is 5.4 percent of the gross District Medicaid budget.

Even though enrollment growth for the aged and disabled has been slower than for children and non-disabled adults, the aged and disabled populations account for the majority of spending growth, as noted previously. The elderly and disabled are becoming more expensive to care for because of price increases in prescription medication and the rapidly rising cost of nursing home services and staffing at facilities for the mentally disabled. These costs combined have increased at a rate much faster than inflation. Furthermore, nursing home and hospital expenses have increased because labor costs continue to increase, driven by a nationwide shortage of nurses and new staffing requirements. And, some of the same factors driving up private health care premiums, such as increases in the prices of equipment, instruments and other staples, also contribute to the rising cost of Medicaid.

Enrollment increases in the District have been attributable mainly to aggressive outreach campaigns and program expansion. Funded largely by the Robert Wood Johnson Foundation, the District has been able to reach 99 percent eligible enrollment status. Furthermore, the implementation of waivers has expanded coverage to groups previously ineligible and/or allowed for services not previously offered or eligible under Medicaid. These include the Childless Adults ages 50 - 64 up to 50 percent FPL Waiver, which has expanded enrollment by more than 1,500 since its implementation and the HIV/AIDS expansion. By treating HIV/AIDS waiverpatients now, the District is spending more money upfront to avoid more expensive future costs. In addition, the loss of income and private insurance coverage during the current economic downturn contributed to Medicaid enrollment increases.

Medicaid Reform and the Future

The District, like many other governments, has been confronted with increasing health care service delivery costs. The more pressing issue for the District has been the estimation and generation of Medicaid revenue by District government agencies that participate in the Medicaid program as providers. The District has attempted to address the challenges associated with meeting complex federal reimbursement requirements by developing the infrastructure within provider agencies to adequately address federal reimbursement requirements and allocating appropriate resources to maintain effective and efficient agency-based Medicaid operations. In June 2002, the Office of Medicaid Operations Reform (OMOR) was established to provide oversight and project coordination of public provider agency based Medicaid operations, integrating the program and financial aspects of the District's Medicaid reform activities. OMOR has focused on four specific areas of Medicaid reform:

- 1) Support the development of the infrastructure to maintain effective agency specific billing operations;
- 2) Facilitate the creation of a District-wide infrastructure to support effective and coordinated financial management of third party revenue;
- 3) Develop a centralized and effective communication strategy to inform decision makers and general public of ongoing public provider reform efforts; and
- 4) Facilitate and support collaborative and cost effective health care delivery among public provider

agencies.

Over the past year, OMOR, working in collaboration with the Office of the Chief Financial Officer (OCFO) and the District's public provider agencies, has made substantial improvements in Medicaid program operations with respect to reimbursement. During the first year of operation, OMOR has focused on the District's most critical operational weaknesses and has worked to develop more realistic revenue expectations and budgetary requirements. Some of the accomplishments are highlighted below.

Implementation of a Medicaid Revenue Certification and Monitoring Process

A major first step in the development of the District's reform effort was to implement a process that ensures reasonable revenue expectations to support the costs of providing services to vulnerable District residents. OMOR has worked with the OCFO to incorporate within the budget process an analysis of agency requests for federal budget authority to support Medicaid services and a mechanism for ongoing monitoring. The certification process was developed in FY 2003 and continues to be refined to ensure that sufficient resources are allocated to support critical health related services to our most vulnerable residents.

Reduction in outstanding cost report submissions

The timely submission of cost reports is critical to effective financial management of the District's Medicaid program. Outstanding Medicaid and Medicare cost reports through FY 2002 have been completed and submitted to MAA for audit and settlement determination. Outstanding issues have been identified in the D.C. Public Schools cost reports and appropriate actions are underway to correct and resubmit those reports.

Develop strategy to sustain/enhance billing operations post contract

OMOR in cooperation with the Child and Family Services Agency (CFSA) has developed an alternative billing strategy for implementation in FY 2004. Currently, CFSA relies on the services of an outside contractor to provide Medicaid cost recovery services. CFSA will serve as the first agency to use this new billing approach that will be available for use by all District public provider agencies.

These efforts should lead to a smoother and more cost efficient system for delivering Medicaid services to District residents, while providing the District with a better system for collecting its fair share of Medicaid reimbursements. In the end, D.C. residents, service providers, and the government should all benefit from improvements to the District's Medicaid program.

Conclusion

Comparisons to recent national Medicaid expenditure trends show that the District's Medicaid program has fared well with regard to maintaining health benefits for the District's Medicaid-eligible population. Unlike a majority of states that are responding to revenue shortfalls by targeting Medicaid for cost containment strategies by reducing provider payments, restricting eligibility and benefits and increasing beneficiary co-payments, the District has continued to fully fund its Medicaid program.

Research from the Kaiser Commission on Medicaid and the Uninsured shows that states will continue to face challenges funding their Medicaid programs and concludes further reductions are to be expected. In the District, the financial plan accommodates six percent growth in Medicaid compared to the three to four percent growth allowed in other spending areas. The challenge to the District is to maintain the current level of benefits when its costs are expected to grow faster than other areas of government.